MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

05031 T

CERTIFICATE OF DEATH

Reg. Dist. No. 168

1. PLACE OF DEATH:
County: Garrett
City or town: Frostburg Md. National Hwy
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Garrett
City or town: Frostburg R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Bradford Blocher

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

B.(b) Name of husband or wife: Mary E. Blocher
6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): Nov 9- 1864

8. AGE: Years	Months	Days	If less than one day
80	5	23	....hrs. ....min.

9. Birthplace: Garrett Co. (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
12. FATHER — Name: Henry Blocher
13. FATHER — Birthplace: Md.
14. MOTHER — Maiden name: Selina Cheney
15. MOTHER — Birthplace: Md.
16. Informant: Geo. H. Blocher
Address: Frostburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 5-1945 (month) (day) (year)
Cemetery or ~~cemetery~~: Blocher
Location: Garrett Co.
16. Funeral director: J. J. Hunt
Address: Frostburg
19. May 3, 1945 (Date rec'd by registrar) Mrs. Julina Michael Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2 1945 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15 1944, to May 2 1945; and that I last saw him alive on May 2 1945.

	DURATION
Immediate cause of death: Chronic myocarditis.	2 yrs.
Due to: Senility	
Due to: Arterio-sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: X Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: X Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. C. Diehl M.D.
M. D. or other
Address: Frostburg, Md. Date signed 5-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

05032 T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22)

CERTIFICATE OF DEATH

Reg. Dist. No. 171

1. PLACE OF DEATH:

County: Garrett

City or town: Accident, R. F. D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: Accident, R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Samuel D. Brenneman

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: SARAH E. BRENNEMAN

6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): Jan. 4th 1867

8. AGE: Years 78 | Months 4 | Days 2 | If less than one day: hrs. min.

9. Birthplace: Accident, Garrett Co., Maryland (Town, county, and state)

10. Usual occupation: Farming

11. Industry or business

FATHER — 12. Name: Daniel D. Brenneman

13. Birthplace: Germany

MOTHER — 14. Maiden name: Susan Beachy

15. Birthplace: Grantsville, R.F.D.

16. Informant: Mrs. Orval Glotfelty

Address: Accident, R.F.D. Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 9th. 1945 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Glade Mennonite Church

18. Funeral director: Wm. Winterberg

Address: Grantsville, Maryland.

19. May 7 1945 (Date rec'd by registrar) J. B. Emmert R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sunday May 6th., 1945, at 11- A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 1 1945, to May 6 1945, and that I last saw h~~im~~ alive on May 1 1945

Immediate cause of death: a Bronco Pneumonia

	DURATION
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. R. Davis M. D.

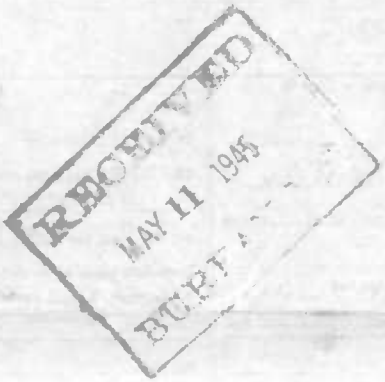
M. D. or other

Address: Grantsville Md. Date signed: May 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
MAY 11 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

T 05033

CERTIFICATE OF DEATH

Reg. Dist. No. 167

1. PLACE OF DEATH:
County Garrett
City or town Oakland, Route # 2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Garrett
City or town Oakland, Route 2, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Wallace Fike

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife ######wife Elizabeth Fike
6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) February 23, 1875

8. AGE: Years	Months	Days	If less than one day
70	2	15	hrs. min.

9. Birthplace Oakland, Garrett, Maryland (Town, county, and state)
10. Usual occupation Carpenter
11. Industry or business General carpenter work

FATHER
12. Name Simon S. Fike
13. Birthplace Oakland, Md.

MOTHER
14. Maiden name Sarah Gauer
15. Birthplace Oakland, Md.

16. Informant Mrs. Elizabeth Fike,
Address Oakland, Route 2, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 11, 1945 (month) (day) (year)
Cemetery or crematory ##### Wolfe
Location near Red House, Md.
18. Funeral director Prentiss Amerman
Address Terra Alta, W.Va.

19. 5/11 1945 (Date rec'd by registrar) Elmer C. Shaffer Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH May 8, 1945 at 9:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/30 1942 to May 8, 1945
and that I last saw him alive on May 6 1945

Immediate cause of death	DURATION
Coronary embolism	5 minutes
Due to Diabetic Coronary sclerosis	
made worse by incontrolable hypo-	
Due to Glycemia	
Other conditions Diabetes Mellitus -	

(Include pregnancy within 3 months of death)

Major findings of operations No operation -
Date of op.
Autopsy results No autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Harold C. Miller M.D. M. D. or other
Address Eglon, W. Va. Date signed 5-10-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

05034 7

Reg. Dist. No. 161

1. PLACE OF DEATH:
County: Garrette
City or town: Friendsville.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, institution, or street address where death occurred: Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Friendsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. ---
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Frank Humberson

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna Humberson
6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): Feb 7 1864

8. AGE: Years	Months	Days	If less than one day
81	3	2	....hrs. ....min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Own Farm

FATHER
12. Name: Noah Humberson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Jane Boyer
15. Birthplace: Maryland

16. Informant: Wm Humberson
Address: Friendsville, Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 13 1945 (month) (day) (year)
Cemetery or crematory: Humberson Cem-
Location:

18. Funeral director: E E Harned
Address: Brandonville, W.Va.

19. May 10 1945 (Date rec'd by registrar) Ira Rush Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 1945 at 10:45 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 10 1945 to May 10 1945 and that I last saw him alive on May 8 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	1week
Due to: Arteriosclerosis	?
Due to: Senility	
Other conditions: Congestive Heart Failure	?

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ....Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H A Shives M.D.
M. D. or other
Address: Friendsville, Maryland Date signed 5-10-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(M) (1) (T) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

T 05035

Reg. Diat. No. 167

1. PLACE OF DEATH:
County: Garrett
City or town: Near Bayard, W. Va.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: West Va. Md. County: Garrett
City or town: Near Bayard, W. Va.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William Summers Kuhn.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Agnes Kuhn.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 30th, 1864

8. AGE: Years	Months	Days	If less than one day
80	7	25	..... hrs. ..... min.

9. Birthplace: West Virginia
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: John Kuhn
13. Birthplace: Germany

MOTHER
14. Maiden name: Mary Marlin
15. Birthplace: West Virginia.

16. Informant: Agnes Kuhn.
Address: Bayard, W. Va.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: May 26/45
(month) (day) (year)
Cemetery or crematory: Fairview Cemetery.
Location: Near Bayard, W. Va.

18. Funeral director: Emroy D. Bolden.
Address: Oakland, Md.

19. 5/31/45 Elmer C. Shaffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24th 1945, at 8:00 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Chronic myocarditis	
Due to	
Due to	
Other conditions: Jaundice (Undiagnosed) Weeks 3 wks	
Tumor Mass - Left Jaw	4 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: E. I. Bannatyne M.D. Deputy Chief Health Officer
M. D. or other
Address: Oakland Md. Date signed: 5/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

05036

1. PLACE OF DEATH (1646)

County Garrett — Registration Dist. No. 167

Village or City Kempton — No. ____ St., ____ Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S. If of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Dora Melvina LEWIS

(a) Residence: No. ____ St., ____ Ward. ____

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
female	white	married

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of: Dewey Lewis

6. DATE OF BIRTH (month, day, and year): January 10, 1901

7. AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	44	4	21	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: ____

10. Date deceased last worked at this occupation (month and year): ____

11. Total time (years) spent in this occupation: ____

12. BIRTHPLACE (city or town): Wilsonia
(State or country): West Va.

FATHER

13. NAME: Benjamin Franklin Willis

14. BIRTHPLACE (city or town): ____
(State or country): Pa.

MOTHER

15. MAIDEN NAME: Nettie J. Burch

16. BIRTHPLACE (city or town): ____
(State or country): West Va.

17. INFORMANT: Dewey Lewis
(Address): Kempton, West Va.

18. BURIAL, CREMATION, OR REMOVAL
Place: Texas Church, W. Va. Date: June 3, 1945

19. UNDERTAKER: J. D. Duncan
(Address): Thomas, West Va.

20. FILED: 6/12, 1945 — Elmer C. Shaffer, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH: May 31 (Month) (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____

I last saw h____ alive on ____, 19____; death is said to have occurred on the date stated above, at ____ m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Drowned in stream, walked into water	
intentional Suicide	

Other **Contributory Causes** of Importance:

Name of operation ____ Date of ____

What test confirmed diagnosis? ____ Was there an autopsy? ____

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Suicide — Date of Injury ____, 19____

Where did injury occur? ____
(Specify city or town, county and State)

Specify whether Injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ____

Nature of injury ____

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify ____

(Signed) Edward K. Bittner M. D.

Acting Coroner Oakland, Maryland

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

T 05037

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-e)

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH:
County Garrett
City or town Oakland, Md. Rout #1 (If outside city or town limits, write RURAL and give nearest town)
How long in above piece of death? Life time
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Garrett
City or town Oakland, Md. Route #1 (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Eva Ellen Lohr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 27th, 1856

8. AGE: Years	Months	Days	If less than one day
88	9	2	..... hrs. ..... min.

9. Birthplace New Germany, Md. (Town, county, and state)
10. Usual occupation House wife
11. Industry or business

FATHER
12. Name Henry Meyers.
13. Birthplace Germany.

MOTHER
14. Maiden name Caroline Durst.
15. Birthplace New Germany, Md.

16. Informant Mrs. E. H. Dudley
Address Oakland, Md. Route #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 1st, 1945 (month) (day) (year)
Cemetery or crematory Meyers Cemetery
Location Near Oakland, Md.
18. Funeral director Emroy D. Bolden.
Address Oakland, Md.

19 May 31 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29th 1945 at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-10-45 to 5-27-45 and that I last saw h... alive on 5-29-45

Immediate cause of death	DURATION
Dilated Heart	
Due to	
Due to	
Old age	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E. H. Bolden Jr. M. D. or other
Address Hampton, Oakland, Md. Date signed 5-31-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15


RECEIVED
JUN 5 1985
BUFFA

Evidence for change of year of birth of deceased is shown

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

105038

FILM No. G 95 MAY 21 1945

Reg. Dist. No. 166

1. PLACE OF DEATH:
County: Garrett
City or town: Oakland, Maryland.
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time - 76 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Oakland,
(If ontside city or town limits, write RURAL and give nearest town)
Street No.: State Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Sarah Ann West McComas.

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Dr. Henry W. McComas.
Deceased 6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): October 28th, ~~1869~~ 1868

8. AGE: Years	Months	Days	If less than one day
76	6	8	____ hrs. ____ min.

9. Birthplace: Swanton, Maryland. (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business

FATHER
12. Name: Richard J. West.
13. Birthplace: Garrett County, Maryland.

MOTHER
14. Maiden name: Martha Fairall.
15. Birthplace: Garrett County, Maryland.

18. Informant: Mrs. Edward Lawrence.
Address: Oakland, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 8th/45 (month) (day) (year)
Cemetery or crematory: Oakland Cemetery.
Location: Oakland, Maryland.

18. Funeral director: Emroy D. Bolden.
Address: Oakland, Md.

19. May, 7, 19 45 (Date rec'd by registrar) Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6th, 19 45, at 1:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1944 19__ to May 19 45
and that I last saw h... alive on May 5 19 45

Immediate cause of death	DURATION
Cerebral Thrombosis	
Due to: Arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

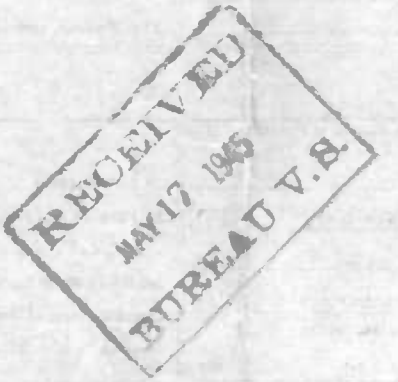
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ____ Injured at work?

23. SIGNATURE: L. J. Baumgartner M. D.
M. D. or other
Address: Oakland Md. Date signed: May 7-1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
MAY 17 1945
BUREAU V.S.

T 05039

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

CERTIFICATE OF DEATH

Reg. Dist. No. 163

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Garrett
City or town Bloomington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 54
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Garrett
City or town Bloomington
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Oliver Clarence Miller

3.(b) Social Security Number 236-03-3972

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Florence Miller
6.(c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) July 22, 1890

8. AGE:

Years	Months	Days	If less than one day
54	9	15	...hrs. ...min.

9. Birthplace Bloomington - Garrett - Md.
(Town, county, and state)
10. Usual occupation Janitor
11. Industry or business Westerner Club.
FATHER 12. Name George T. Miller
FATHER 13. Birthplace Bloomington Md.
MOTHER 14. Maiden name Mary Poland
MOTHER 15. Birthplace Bloomington Md.
16. Informant Carson Miller
Address Bloomington, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 20 1945 (month) (day) (year)
Cemetery or crematory Pleasant Cemetery
Location Westernport Md.
18. Funeral director Ellsworth & Boyle
Address Westernport Md.
19. May 19 1945 (Date received by registrar) Dewey Patterson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1945 at 11:2- M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb-1- 1945 to May 17 1945
and that I last saw h--- alive on May 17 1945

Immediate cause of death	DURATION
Acute nephritis	3mo.
Due to	
Due to	
Other conditions Hypertension	2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE F E Berry M.D.
M. D. or other
Address Piedmont W Va Date signed 5-7-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 168

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Garrett
City or town: Frostburg R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany (Garrett ?)
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Hazel M. Pressman

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 10 - 1895

8. AGE: Years	Months	Days	If less than one day
49	11	2	..... hrs. ..... min.

9. Birthplace: Frostburg - Alleg - Md (Town, county, and state)

10. Usual occupation: school teacher

11. Industry or business

FATHER
12. Name: Peter Pressman
13. Birthplace: Frostburg, Md.

MOTHER
14. Maiden name: Mary A. Workman
15. Birthplace: Frostburg, Md.

16. Informant: James Pressman
Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15 - 1945 (month) (day) (year)
Cemetery or ~~crematory~~: M.Y. Zion
Location: Nath. Highway - Frostburg

16. Funeral director: J. J. Dudley
Address: Frostburg

19. May 14 19 45 Mrs Julius Michael
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 19 45, at 8 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4 19 45, to May 12 19 45
and that I last saw h. alive on May 12 19 45

Immediate cause of death	DURATION
Carcinoma Brain	4 mo
Due to Carcinoma liver or pancreas	—
Due to Primary in liver	
Duration: Six to eight months	
Other conditions C. in S. R.	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Hilda Jewell Hess M.D.
M. D. or other
Address: Frostburg Md Date signed 5/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (158)

CERTIFICATE OF DEATH

1
05041
Reg. Dist. No. 164

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Garrett
City or town: McHenry
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days): 2 days old
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: McHenry, md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Benjamin Franklin Shaffer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 5-9-45

8. AGE: Years | Months | Days: 2 | If less than one day: hrs. min.

9. Birthplace: McHenry Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Edward E. Shaffer
13. Birthplace: McHenry Md. Bedford Co Pa.

MOTHER
14. Maiden name: Blanche Catherine Schroyer
15. Birthplace: Cargenville Maryland

16. Informant: Edward E. Shaffer
Address: McHenry, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 12/1945 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Hyndman Pa
18. Funeral director: H. F. Fraylor
Address: Hyndman, Penna.

19. May 14, 1945 (Date rec'd by registrar) Emmard D. Spaarlin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10th 1945, at 10.A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-9-45 to 5-10-45
and that I last saw him alive on 5-9-45

Immediate cause of death	DURATION
Weakness	2
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Edward E. Taylor M.D.
M. D. or other
Address: Oakland, Maryland Date signed 5-10-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

05042

Reg. Dist. No. 17

1. PLACE OF DEATH: Garrett
County: Vindex
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2½ Months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: W. Va. County: Grant
City or town: Scheer (If outside city or town limits, write RURAL and give nearest town)
Street No. 1½ Above Scheer (If rural, give LOCATION)
2.(a) If veteran, name war: no ✓

3. (a) FULL NAME: Otto Sherman Weasenforth

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Elizabeth Catherine (Hawk) Weasenforth
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 7, 1855

8. AGE:

Years	Months	Days	If less than one day
89	5	6	..... hrs. ..... min.

9. Birthplace: Scheer, Grant Co., W.Va. (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business:
FATHER — 12. Name: —
13. Birthplace: Germany
MOTHER — 14. Maiden name: Cass Amtowers
15. Birthplace: Germany
16. Informant: Mrs. Verna B. Teter
Address: Vindex, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 15, 1945 (month) (day) (year)
Cemetery or crematory: Weasenforth Cemetery
Location: Scheer, Grant Co., W.Va.
18. Funeral director: Otha F. Sharpless
Address: Blaine, W.Va.
19. 5-14-45 (Date rec'd by registrar) A. W. Barnett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 19 45 at 12:50P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 45, to May 13 19 45
and that I last saw him alive on May 13 19 45

Immediate cause of death: Acute Myocarditis — DURATION
Due to: Auricular Flutter
Due to: Hypertension
Other conditions: Right sided Heart Failure, Pneumonia & Emphysema
(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Indusfry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Ralph Calandrella M.D. M. D. or other
Address: Kingwood, W.Va. Date signed: May 14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

T05143

Reg. Diat. No. 171

1. PLACE OF DEATH:
County: Garrett
City or town: Near Fairview
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Near Fairview
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Rhoda Savilla Wilt

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife: Stephen Wilt (deceased)
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 11th, 1864

8. AGE: Years	Months	Days	If less than one day
80	7	20	..... hrs. ..... min.

9. Birthplace: Avilton, Garrett Co., Maryland. (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business

FATHER
12. Name: William E. D. Broadwater
13. Birthplace: Fairview, Garrett Co., Maryland.

MOTHER
14. Maiden name: Sarra Ann Weitzell
15. Birthplace: Avilton, Garrett Co., Maryland.

16. Informant: Clarence Wilt
Address: Swanton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 3rd., 1945 (month) (day) (year)
Cemetery or crematory: Rounds Cemetery
Location: near Bond, Garrett Co. Md.

18. Funeral director: Wm. Winterberg
Address: Grantsville, Md.

19. May 2 1945 (Date received by registrar) J. R. Emard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1st., 1945, at 3 AM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1 1945, to May 1 1945
and that I last saw h.. alive on April 15th 1945
Immediate cause of death: Cerebral Hemorrhage — DURATION
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. A. Davis M.D. M. D. or other
Address: Grantsville Md. Date signed May 1

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING